MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 18, 2001
10:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Quality improvement for health plans and providers
Karen Milgate, Mary Mazanec

MS. MILGATE: For the next hour or so we're going to be talking about the question of how Medicare should apply quality improvement standards to the Medicare+Choice and the fee-for-service program. This is, in fact, one of the tools that CMS and Congress have to take what Dr. Berenson described this morning as a step-by-step approach, in fact, to Medicare potentially leading in the area of quality improvement.

In answering the question, Congress asked MedPAC to consider the feasibility of applying standards that are comparable to the Medicare+Choice quality improvement standards to all types of providers and plans. So that's really the centerpiece of the analysis that MedPAC staff have begun so far.

This request was included in the Balanced Budget Requirement Act of 1999 in response to the controversy over how to apply Medicare+Choice quality improvement standards to all types of plans in the Medicare program.

In the BBA, Congress enacted the Medicare+Choice program and applied quality improvement standards to all plans, but recognizing that these standards did represent a more rigorous approach to quality regulation, they thought it might be difficult for some types of Medicare+Choice plans to meet those requirements. So they exempted non-network MSA plans and private fee-for-service plans from a portion of the requirements that required plans to actually demonstrate improvement.

And then they went ahead two years later in the BBRA to exempt PPOs from those same requirements. So this created the unlevel playing field between Medicare+Choice plans and it was unlevel from two perspectives really, from the PPO or non-HMO perspective it was unlevel because for them to meet the standards it was difficult, if not impossible, some of them suggest, and very expensive and didn't recognize, they argued, the value they bring to consumers which is really a broad choice of network.

For HMOs, they considered the playing field unlevel because they had to put out resources to meet a higher level of standards but they weren't playing any more for putting those resources in place, so they argued this gave them a market disadvantage that perhaps they wouldn't be able to, for example, provide as rich of a benefit package as the non-HMOs might be able to provide.

Both plan types, however, agreed that this created an unlevel playing field between programs. They argued that the requirements in Medicare+Choice were more rigorous than those applied in the fee-for-service program. And we'll talk just a little bit later on some comparison between the two programs, as to see whether that is, in fact, true or not.

To help answer the question and to address the issue, MedPAC staff has interviewed numerous purchasers, different types of providers, various types of plans, accreditors, state regulators, and of course, talked extensively to CMS personnel to understand

more about the Medicare+Choice standards themselves.

We've put in your meeting materials, under Tab C, three background pieces that are the results of this research and talking to various officials that do two things. One, it identifies the goals of quality improvement and then the various ways to apply quality improvement standards. That's your background paper one.

And then we analyzed the Medicare+Choice standards and the fee-for-service quality improvement efforts, which are background paper two and three, to really get a sense of the current regulatory environment to compare quality improvement efforts across the programs, and then to identify some of the problems with applying Medicare+Choice-like standards to different types of plans and providers.

Using this information what we learned about the provider and plan ability to actually perform quality improvement, we then evaluated the feasibility of applying Medicare+Choice-like standards to each type of provider and plan.

So what is the goal of quality improvement standards? Broadly speaking, the goal is to close the gap between what we know to be good care and the actual care that's delivered to patients. We know that in many clinical areas there are well accepted and well known ways to deliver care that do not always reach the bedside.

One example that illustrates this is beta blockers after heart attack. It's well known that if a patient does receive beta blockers after they've had an initial heart attack that it can often prevent another heart attack from occurring. But in data that was released from the PRO program last fall, it showed that the median rate for patients being discharged with a prescription of beta blockers was 72 percent. Meaning that 28 percent of the patients, in fact, sort of lost a chance to get a prescription for something that could have prevented a heart attack from occurring in the future.

In addition to problems in specific clinical areas, there is also growing concern over the prevalence of medical errors which affect all types of patients. The IOM report that was released a couple of years ago documented this gap in quality and talked about steps to perhaps solve that issue as well.

So what do quality improvement standards require organizations to do that actually help us move toward that goal of closing the gap? There's really three steps, as we talked to various types of organizations that try to implement quality improvement standards.

The first is to establish systems to measure the quality of care, then to use the information about the problem that they may have identified to put in place interventions that will influence either the system or clinician behavior. And then thirdly, and this is really the new piece of the standard that's different, in essence, than the more regulatory approach to quality improvement. And that is to actually demonstrate the results of what they do to a third party. Sometimes this takes the form of the requirement that you show you've actually improved on something. Other times, because the regulators or oversight

agencies aren't as clear about whether you could improve or the level of improvement, it merely requires the organization to report in the results of their measurements.

Questions arise in this area about how meaningful the data are. For example, if sample sizes are not large enough maybe they don't really tell you anything significant about the organization. And there's also always the question of how possible it is for the organization you're holding accountable to really change behavior on whatever you're measuring them on.

The Medicare+Choice quality improvement standards really have two parts. The first is they are required to establish a quality assessment and performance improvement program. This includes standards like putting in place an appropriate information system for collecting data. Often the source of data would be either claims, looking at claims, abstracting information from medical records or surveys, having the appropriately trained personnel, making sure you get the right input. For example, the QA/QI standards require organizations to have appropriate input from enrollees and clinicians.

And then also, they're very specific about the types of criteria that you need to use for choosing projects to work on and how you analyze your effectiveness on this project.

They require that organizations demonstrate the results of their efforts by reporting on two QAPI projects. On these projects, CMS requires plans to actually show improvement. When they began, when they put these regulations in place, at first they had a 10 percent minimum requirement. CMS has since backed off on that because of concerns that, in fact, they really didn't know why they had chosen 10 percent. It was unclear that that was really a good goal. It was also unclear, for some plans, whether they could actually reach that given that the criteria and the sophistication of the QAPI projects were beyond many plans who had not measured things at this level before.

Secondly, they have to report on HEDIS Medicare measures. This is an example of building on private sector efforts. For those plans that are experienced with NCQA accreditation, these types of measures are very familiar to them. For plans that aren't familiar with NCQA accreditation, this was a whole new level of infrastructure for them to have to create.

However, they are not required to show improvement on these measures. They simply have to report. The assumption is that if they measure what's going on in these areas that they will do something to improve upon their performance in those measures.

The third piece is CAHPS, the Consumer Assessment of Health Plans Survey, which is actually administered directly to beneficiaries by CMS. So it really adds no extra cost to the plans. This is really a look at beneficiary perception of both the plan and the providers within the plan. Questions like how good do you think your care is? Is this the best plan? Or is it not as good as you would like? Waiting times, how available providers are, getting at some issues you had talked about earlier, Allen.

Non-HMOs are exempt from the two QAPI projects. That's really the regulatory extension of the exemption that was in

legislation from demonstrating improvement. So they do not have to do those projects or show improvement, obviously, on those projects.

Plans have told us about a variety of different problems they have with how these are implemented. They, I think, can be categorized in two broad areas. One is they think that they represent stretch goals. That essentially these are not bad QI efforts, but question whether it's reasonable for a regulator to actually be putting these types of stretch goals in place as requirements.

Secondly, they feel like there's a lot of duplication, both at the standards level as well as the reporting requirements level, between what CMS is requiring and what other oversight bodies require and don't think it's necessary that this duplication exists. They don't think there's enough extra quality improvement achieved by simply some other requirements being placed on them.

In the fee-for-service program, the quality improvement efforts really operate at two levels. When we say plan level, we're talking about essentially CMS in the role of administrator of a benefit package for the Medicare beneficiaries. What they do to put in place the infrastructure that's required in Medicare+Choice plans is basically to use the PRO program as their infrastructure to measure quality of care, as well as to improve the quality of care. They do do some independent analysis of claims data, but the PROs do the medical record abstraction and then are really the foot soldiers on the ground to work with different types of providers, plans, and even beneficiaries to try to improve the care that's delivered to Medicare beneficiaries.

For example, beneficiaries, they tried to influence them directly in the area of immunizations, recognizing that the demand for immunizations is one important factor in improving on that particular measure.

They report on the results of their effort through -- on the PRO measures, there are six focus areas and they report publicly on those. They also use a fee-for-service version of CAHPS. And then are trying to develop the ability to compare between fee-for-service program and the Medicare+Choice program in various areas by reporting on some HEDIS measures that would overlap with the PRO measures.

At the provider level, there really are a lot of voluntary efforts, but few requirements at present. Many providers are accredited and often by the Joint Commission, which does require that institutions have in place quality improvement processes. They also work voluntarily and increasingly so with the PRO program to improve care in certain areas. And then of course, providers have some of their own initiatives that aren't associated with external efforts.

CMS has tried to put in place some requirements through the conditions of participation for various institutions to establish quality improvement programs and those eventually will come out in final form. But as of yet, they have not been finalized.

They also are talking about, and this is probably the most

significant discussion occurring in CMS right now, about how to use reporting requirements on various institutions to stimulate quality improvement within those organizations. They do require some reporting on measures for home health agencies, nursing homes, and dialysis facilities but they're thinking about how they might expand those efforts to encourage and stimulate quality improvement.

So given what we know about Medicare+Choice standards -- actually, let me call your attention to the chart that we placed in front of you. It was in your meeting materials, but a larger version we placed in front of you before the presentation, because this is really the guts of the analysis.

Given what we know about Medicare+Choice standards and what we know about how plans and providers can actually perform quality improvement, we asked two questions. The first question is how capable or how feasible is it for different plan types and providers to actually meet Medicare+Choice-like standards? And once we get a sense of how difficult or easy it is for those types of plans or providers to meet those standards, could we actually hold them accountable for meeting those standards?

So just to look at the Medicare+Choice HMOs, many of them do have the infrastructure to measure the quality of care and to influence behavior of providers and clinicians to improve their care. This is true for many, but not all. There are small plans that don't have that capacity. There are plans that are not familiar with accreditation, and so it is a whole new infrastructure for them.

Can they demonstrate the results? Generally, their results would be valid. They usually have broad enough populations, although once again with small plans that would not be the case.

So could they be held accountable? Clearly, they could be. The question here, as we've talked to various plans and CMS, is really whether the current level of effort is necessary to achieve the extra quality improvement that may be achieved by placing these standards on HMOs, and if there are ways possibly to lessen the burden on how the M+C standards are applied.

For non-HMOs, it really varies as to whether they are able to measure the quality of their care. Those that are affiliated with HMOs, meaning they may be offered by a plan that has an HMO as well, oftentimes do have the infrastructure to measure what they're doing. However, they told us that even if they have that infrastructure, it's very difficult to apply it.

There's really three factors that are important here. They have much broader networks than HMOs usually. They don't require beneficiaries to choose primary care physicians. And they also allow beneficiaries oftentimes to go out of network. So this causes problems both for measuring and improving. Essentially, they don't know where to go to get the information. It's very difficult, at least. They don't have a primary care physician to look in the medical record for some services to see if the service was provided. There's many different places they could go.

This also makes it difficult for them to focus their improvement efforts. They also have some many different

clinicians that they need to influence they don't know really which the right one is. And so, it's very difficult for them to apply an infrastructure even if they have it.

In terms of them demonstrating their results, they often do have a broad population. But clearly, if the data you collect are not accurate, it's not going to be very useful for measuring you.

They do, however, have fairly good capacity to measure care on measures that rely on claims data. So that's one thing to keep in mind. It's very difficult for them to go into medical records, but they do have good claims data. So they could be held accountable.

It appears that it would be very difficult to hold them accountable to the same level as the HMO without really demanding that they change their structure from a PPO or broad network structure to a tighter network. However, there may be ways to assist them in measuring their quality or helping them put in place interventions. And it might be possible to hold them accountable for different measures, particularly ones that are based on claims.

For the fee-for-service program, as a plan, they do have the infrastructure to measure. They have pretty good capacity and mechanisms to influence the behavior of providers. They could perhaps use that even more than they do. They don't currently require providers to participate in the PRO program, for example. And their statistics are valid. We don't really know the results of the current voluntary efforts, so it's hard to know whether any higher level of accountability would be useful or not.

For institutions and clinicians, the answer really varies by size. Some are more sophisticated than others. However, the biggest difficulty is really finding measures that are useful for comparison. So you could perhaps require some process or some participation with other efforts, but it would be difficult to use the same measures.

In summary, all plans and providers do seem to have some capacity to measure improved quality of care, however the cost of meeting the Medicare+Choice-like standards is really unequal across plan types and providers. But strategies do exist to reduce those costs and to move towards the goal of improved care for Medicare beneficiaries.

That concludes my presentation. I would be glad for any questions and, in particular, comments on the direction of our analysis and any comments specifically on how to apply quality improvement standards to different plans and providers.

MR. HACKBARTH: Let me just first welcome our guests now that everybody is in their seats. Thank you all for coming and we appreciate your interest in our work. As in the past, there will be a public comment period at the end of the day. Those of you who have a contribution to make will have a chance to offer that to the Commission. Or even at the end of the morning, I'm reminded. So it's scheduled at 12:30 and that will be the first comment period.

Thoughts about Karen's presentation?

DR. NEWHOUSE: First in the way of disclosure. I should say

to people that I was elected a director of Aetna in late September. So I hope that won't much affect what I say here, but people should know that.

I should say, speaking personally, I found this a really hard issue. In some sense, the hardest issue, I thought, of the mix on our platter here. I had a few thoughts about it. One was a thought that has come up earlier, which is to distinguish standardization of measurement and information tools from trying to standardize actual care delivery and regulations directed at that. I think we've done a somewhat mixed, but on the whole pretty good record there.

Second, my general bias is for what I'll call within sites of care, to try to decentralize the regulation and try to use deeming as much as possible.

The third thought is that M+C plans, especially those, which I think are most of them, that use non-exclusive contracts are likely to be too small to do very much in many cases. So it's kind of pointless to hold them responsible. They just don't have the leverage.

MR. HACKBARTH: Joe, too small in terms of having too small a share of the patient volume with an individual provider?

DR. NEWHOUSE: Yes, too small a market share.

The fourth thought, the last one, is that in terms of thinking about M+C plans and HMOs and maybe this applies to PPOs, too. It seems to me where their largest value added is is likely to be on the coordination function. We know that there's lots of quality problems that arise in handoffs from one site of care to another site of care. The traditional plan, it seems to me, mostly relies on the PCP to watch over this handoff. The HMO actually kind of sits there above this in a way that there's no analog for on the fee-for-service plan, could conceivably do something here.

It seems to me it makes more sense to think about a role for the HMO in that domain than it does to say improve beta blockers after heart attacks, where you could go down to either an accreditation agency or you could have the PRO at the local level working on that, rather than say this is the HMO's responsibility.

MS. BURKE: Actually this is very consistent with what Joe has suggested with perhaps the following slight deviation. I think, in fact, because it is so complicated for non-HMO plans and for plans with smaller volumes to understand how it is, in fact, they might control the outcome, it is incumbent upon us, I think, to help them identify the tools that might be available to them and how they might, in fact, begin to influence this behavior.

I think there is going to be a growing number of people potentially who choose those options. And to simply give up on efforts to have them play a very major role in trying to both track, as well as influence behavior that has an impact on quality, would be to leave outside of this a fairly sizeable portion of the Medicare population.

So I would hope as you go through -- and I found the chart to be quite useful. I thought you did quite a nice job of laying

out for us the sort of array of issues that exist, depending on the structure of the plan. I think some emphasis on those that fall outside of the traditional HMOs, that do have the tools available more readily, and focusing on the traditional fee-for-service and the sort of non-HMOs in looking for how they might team up, looking for tools they might have available, looking for ways that we can, in fact, assist them in identifying methods of influencing this is time well spent for us. I think we can't simply give up on that and turn simply to the HMO structure and assume that will be the only solution.

DR. ROWE: I'd like to ask Sheila a question, if I can. I was surprised to hear you say it's a substantial portion of the Medicare population. The whole M+C program is 4.5 million members now. The non-HMO piece would be how many members?

MR. HACKBARTH: It rounds to zero.

MS. BURKE: Right. My reference was really in the broader context, Jack, not just to the M+C but rather the fee-for-service and all the other sort of models.

DR. ROWE: Thank you, that clarifies, because I think focusing on the non-HMO piece of this is almost not worth the type here.

MS. BURKE: My point is those outside of a traditional M+C HMO in the rest of the program are the large majority, and that we ought to look for tools to assist across the board, was my point.

MS. NEWPORT: I think Sheila is right in terms of the tools. Even in what we look at as a company, where we may be a small part of the market geographically literally, what we're trying to do is have some quality programs and disease management programs that, by raising the bar for a portion of the patient base, we raise the bar for the rest of the patient base, too. It does have an influence.

And we are trying to identify and make public our own quality measures of provider group activity, and therefore steer patients to groups. Now large multi-specialty provider groups find it much easier to participate in these programs, but I think that the bar needs to be raised and tools can be segmented differently.

I appreciate very much, I think you captured the scope of the problem and the difficulty in trying to be too granular here, in terms of the offset, loss of productivity or increased costs. And having been subjected to my own medical director's four-and-a-half long dissertation on how we measure quality -- and they are paid to do that, by the way -- it is a difficult program.

I would hope though that people would appreciate that there were some howls, very loud ones, about CMS's -- then HCFA's -- programs on quality assurance. I wanted to be clear that the problems were with chancing horses in midstream, literally. We would have disease management protocols that had been put in place because of our intent to be NCQA certified, which is a very intensive process, only to see things that are iterative and need to grow over time be supplanted by something else that we weren't doing.

There were certain disease management, diabetes being a very

critical one. And then the next year there was going to be a whole class of other four disease management programs that you had to do.

So I think it's very important to have focus on continuity and consistency and achievable measures. A 10 percent improvement every year, when you're meeting a quality of index of 92 percent, the last gasp that you have to reach for, the bridge too far literally, is diverting resources from some other program that might benefit from a 2 percent incremental improvement over time, or those areas where you needed to go 20 percent because the indices were so low.

So again, I compliment you on the breadth of your analysis. I think you've captured the problem. I think some refinements in making reasonable tools available and incentive to the program that might -- and I mean from quality competition -- might bring providers along even subtly in terms of the effect you can have in patterns of practice in a marketplace -- if I can be bold enough to use marketplace in this instance.

I do think that there are ways that you can do that, and that we're seeking to reward better quality performance as much as anything else in terms of a provider's ability to get a full panel of patients.

DR. NELSON: I also thought that you did very nice work with respect to these papers. I want to make just three points and it's largely from the standpoint of clinicians rather than plans.

The first is to again point out the distinction, to some degree the mutual exclusivity, between quality assurance and quality improvement. The Commission has dealt with that distinction in previous reports, but I think it's always useful when we're talking about quality standards to point out that one is sort of externally applied and has more of a regulatory impact, and that quality improvement, on the other hand, depends on a different set of assumptions.

The PRO program, for example, has struggled with these competing requirements throughout the last 10 years. The Joint Commission as well has certain quality assurance minimum standards, but then also to try and encourage introspection and self-examination and team application of quality improvement efforts. And it's still struggling. But to reference that distinction again is useful, even though we've dealt with it before.

The second point is to underscore the difficulty in getting data from the outpatient clinical record. We've done some work 25 years ago in Utah in having trained nurse auditors go into the physician's office and sit in the waiting room, in some instances, or back in an examining room in other instances, and try and abstract data for quality assessment. If nothing else, it's extraordinarily expensive and burdensome and difficult. You make the point, but I want to underscore it.

I think it's worth pointing out that one of the reasons for that is that the clinical record was developed for a different purpose. It wasn't developed for purposes of accountability. It's a tool that clinicians use to aid in patient care. Even

though increasing use of a problem list and flow sheets and so forth make some data collection easier than it used to be, still it's extraordinarily difficult.

At ASIM we did some work in simple measures, like hemoglobin A1Cs for diabetes and monitoring the anticoagulation status in patients on warfarin, and so forth. Even with volunteer physicians signing up to do this and following relatively simple protocols, it took an enormous amount of work and dedication. They'd stay late at night and try and find the bloody records and get the information from the records. Until there is a widespread adoption of a new kind of recordkeeping that employs an electronic medical record, it isn't going to get any easier.

So the practical application of some of these rules needs to be underscored.

The third point that I want to make is that it's probably worth acknowledging that the specialty boards are moving rapidly into performance measurement as part of their recertification processes. Of course, it's being met with a certain amount of skepticism and, to some degree, anguish because of the difficulty in getting information from the medical record. But I think that the commitment isn't going to go away, that the recognition of public expectation is going to continue.

It may be worth including some reference to that level of activity. Because at some point, that may provide a solution with a deeming and private sector activities that the Medicare program can simply ride on board.

DR. ROWE: Just a couple general comments. I think I'd like to associate myself with Janet's remarks, from the point of view of another health plan that participates in the program.

I would note that I think that CMS has been responsive and is mindful of the burden. They have, I think, dropped that 10 percent requirement of an annual increase, mindful that the last 2 percent is different from the first 10 percent in costs and feasibility, et cetera.

I think that the general discussion is very good. I would suggest that you drop out the non-HMOs. If you look at the table and if you read the material, just given that it's a rounding error or it rounds to zero, it's really not -- we need to focus on the important piece of this, I think. You might have it there as a section at the end, that this is a very small program and it's different. It's not a big deal, but someone not knowing a lot about this and looking through this, you don't get a sense of the relative proportions here. Maybe you could include those data somewhere, in terms of relative proportions, how many Medicare beneficiaries are represented or something like that.

I guess the most important comment, or the comment I'd like to emphasize, is that I think in the overall Medicare+Choice program -- let's step back a bit -- there has been some disappointment that there has not been a modification of the funding amounts or mechanisms. There's been some, but I think most people think modest withdrawals recently, compared to what was expected. But they are likely to continue if there's not a change.

There's been discussion from CMS that yes, we can't give you

anymore money, but we can help you on the regulatory side. We could try to reduce regulation that might be burdensome or costly, directly or indirectly. We don't want to add more barriers to participation in the program.

I think that that is what I've heard, at least, and I think that that's well received.

One might look at this issue from that point of view and say we don't want to back off completely from issues of quality. I think that would send the absolute wrong message. That would be just stupid to say well, we're going to help them on the regulatory rather than financial side, so forget these quality measures. That's not what managed care is about fundamentally, I believe, and that would be an atrocity. Nobody wants to go there.

But to whatever extent we can make the requirements here concordant with the form and the substance with the requirements that the health plans have with NCQA or in other things, so that we don't have two different mechanisms and two different kinds of data, then that reduces the burden financially and in other ways, and gets us to a standard which is generalizable to some extent.

So I think that would be a kind of principle that I think is worth applying to this while maintaining a focus on quality.

MS. RAPHAEL: I wanted to address the part that had to do with the fee-for-service side and some of the issues that exist there. First of all, I was very interested in some of what you wrote, although I think it needs to be expanded on, on the extent to which you can use conditions of participation more vigorously. I think there are issues about easy entry. And right now, there's very easy entry. I would like to have more thinking around whether or not that ought to be changed and whether there's more that can be done at that level.

I know in the home health care field there was a point where practically anyone could enter the home health care field. There were people who had jewelry stores during the day and then changed the sign in the afternoon and became home health care providers at two p.m. And I think some of that has been rescinded in the last few years. But I think that whole issue of entry needs to be looked into.

I've often been told don't enter into anything that you can't exit from. And I think the whole issue of exit, too. And I think the point is made that almost no one ever exits the program except voluntary. I think I'd like to better understand the whole issue of the kind of mechanism of exit and how it works or doesn't work effectively in the fee-for-service program.

I am not as taken with the issues of reporting. I recognize all the issues about the necessity to have valid and credible data. But I think the greatest challenge isn't that, because we're getting a tremendous amount of data now. I think the greatest challenge is how do you change behavior at the clinician level, where you -- in this what I thought was well done effort here -- indicate that clinicians have the greatest ability to influence clinical quality except it's too much of a burden for them often to collect, and they can't get valid results on an individual level.

To me that's sort of the crux of this. I mean, how can we influence what happens at the clinician level? I think we have to think about how we're going to work at that level, not only at the organizational level and the health plan level. And that is very difficult to do.

We're engaged in a major project now on changing wound care practice. 20 percent of our admissions have wounds, a variety of wounds. And how you change how every practitioner handles the wounds is very complicated because you have to interact with physicians who are using treatments that may be 20 years old or that they learned in medical school. There are many new advances. It's not just a matter of how you report on it. The hardest part is how do you really get results and demonstrate improvements?

I also think there needs to be some looking at this issue of collecting data for payment systems and then using it for quality. I have some experience with that where we're doing this massive dump, sending in all this OASIS data which we use for payment. And then it's supposedly going to be used for quality.

I'm not sure that that's going to work very well. I think it raises other issues. I think it does heighten awareness about, for example, a high level of emergency use. But then, when you see CHF patients going back to the emergency room in one out of three cases, you ask yourself does that indicate too early discharge? Does it indicate inadequate follow up by the physician? Or have we, in some way, not done what we should do? So I think that that is another issue that needs to be looked at.

And then lastly, I think there is a lack of incentives in the whole payment structure for good quality. Quality can save money because if you do things well you don't have to do them three times. And anyone who's dissatisfied costs you a lot of organizational energy. But also, to put in the infrastructure and have the tools also costs money. And I don't think the incentives are aligned now to really support what everyone says is really vital.

DR. WAKEFIELD: I want to just start by agreeing with Joe. I thought this area of focus was awfully difficult. When I was reading through it, and I do a little bit of work in quality, I really appreciate the challenge that you have.

I think the question for me was should all of M+C be subjected to quality measurement for the purposes of accountability? In an ideal word the answer, from my perspective, would be yes and there would be comparability.

I might even step back from that, and my comments are pretty general regrettably, but I might even step back from that and say should the entire Medicare program be subjected to quality measurement? And should there be comparability and similarity where it can occur across those measures? And I think the answer to that would be yes.

The tough part is coming up with the approaches about how to get there.

Some of what I think is coming out of the National Quality Forum might be relevant, and you've taken a look at it obviously because you've cited it in your work, in terms of some guiding

principles. I'd comment a little bit on some of what Dave had to say and then my own views.

One, there's measurement for accountability and measurement for improvement. Sometimes those two things are distinguished. But clearly, I think there needs to be some overlap. Those purposes should be mutually reinforcing.

And improvement, quality improvement, is often motivated by external accountability. And some of your content suggests that that's the case, that we get improvement when entities are required to be accountable to some external entity. Whether that's CMS through the PROs reporting to them, or it's broader public disclosure, wherever along that continuum.

The point, though, that I think accompanies that is accountability measures are really only effective, from my perspective, if they relate to improvement measures that plans or providers can actually take action on. Is it in the M+C's ability to do something about whatever X is? Are they truly able to exert influence in a particular area? So when we're thinking about accountability, it's accountability for what and is it within their scope to be able to exert influence?

I also think ideally that data, when we're collecting data -- and this theme comes through I think a little bit in your writing -- data should be collected once. An organization should be asked to collect it once. I think, typically that data should be collected as close to the point of the care being provided as possible. And to the extent we can, we reduce the burden on providers in obtaining that data. And that we ensure that we're constantly filtering to make sure that the data are relevant to patient care ultimately, that it's useful.

And we've talked a lot about the burden of data collection on providers. But I also think there's another burden. And that is whether we're asking for the collection of data that's not directly useful to the entity that has to collect it. So it's yes, there's a burden associated sometimes with the collection of data, but there's sure a burden associated with it if they're going through the motions of collecting information that's frankly not relevant. What are they going to do with it once they get it?

I think, to the extent we can encourage plans to not have to report in multiple, incompatible ways, across private sector and public requirements, to beat some efficiency into this system, it seems to me would be a guiding principle we ought to be thinking about.

The last point I would make is that, in general, you made the point about volume of services and that an event needs to happen often enough for a meaningful measurement. I think we all know that.

So should we be thinking about making a comment about how data, when they can be, should be rolled up and aggregated to a level of aggregation that's relevant and valid? For example, I can imagine detailed data that's relevant for quality improvement. So you might collect information on beta blocker performance. That's just used internally across some subset of providers.

That same data will be invalid for cross-provider comparisons. So data collection might be appropriate at one level but not another. But if we had some, over time, appropriate investment of measurement methodology and research, over time we might be able to find ways to aggregate and collect information and make it meaningful at multiple levels.

But right now, just because it's not relevant at one level may not render it irrelevant at another level. So there's a point.

I think that's it, just some general comments.

MR. HACKBARTH: As I look at the overall framework that we have, it seems one of the guiding policy objectives is to offer Medicare beneficiaries a range of choices in the program and a variety of others, ranging from private fee-for-service to MSAs to PPOs to HMOs.

A concern that I have is that imposing a single set of requirements for quality improvement on what are diverse systems and capabilities by definition, will frustrate the goal of choice. The capabilities of these organizations are different, and to have a uniform set of expectations, I think, is going to lead to frustration and -- at least in the case of many organizations -- departure if that's a feasible option for them, exit.

One of the questions we were asked by the Congress is should the same requirements that are imposed on HMOs be imposed on everybody else and level up, if you will, to that level. To me, I think that's a course that's full of risk because not all organizations are organized the same way, have the same capabilities.

Instead, I would be more inclined to say if we want a uniform approach, what we ought to do is a level more at the approach now being taken in the fee-for-service Medicare program, as I understand it, which emphasizes voluntary quality improvement efforts. That's not to endorse the specifics of what are being done, but the general approach.

What I would like to see us expand on perhaps is the way that we try to reward and encourage and support those voluntary quality improvement efforts, so that there is actually a reason for people to want to do it beyond the fact that they're committed to trying to do the best for their patients. It could be financial, as Carol pointed out. It could be in terms of information disclosure, quality scores or measures of some sort. It could be a seal of approval as provided by accreditation that is then marketed, if you will, to Medicare beneficiaries that certain organizations have invested more and they have different capabilities than others.

Some might say that emphasizing voluntary and rewards and encouragement is to weak, given what some people -- I guess the IOM -- characterize as a chasm between what we know about proper medical practice and what, in fact, happens every day. Like Jack, I think we should not be considering backing away from efforts to improve quality. It's not the end that's in question but rather the means.

But I think we have to be realistic about what we know about

quality improvement. We have to be realistic about the capabilities that people have to do quality improvement at this point in time, and to be realistic about the costs involved. And we need to walk before we run.

I think the surest way to give all of this a bad name and spawn a terrible reaction to it is if we tried to do more than we can given our knowledge and our resources.

So I would like to reward voluntary efforts as aggressively as we can figure out how, but let's not level up and impose unrealistic requirements across the board in the name of equity or uniformity or an even competitive field.

MR. FEEZOR: Glenn, following up on your comments, I've sort of changed some of the things that I was going to say. But let me just say, and we'll come back to this a little later in the day, I think the choice is largely -- at least from my post in California, in watching the market for both over-65 and under-65 that I try to serve -- that choice is more of a political construct. What our beneficiaries really want is value and security and they have a way of measuring that very fast.

I agree, Glenn, with your comments that it is fraught with difficulty to try to level up to the M+C plan level. And yet, I don't think -- I guess I agree with Sheila that given at least the retreat in terms of the M+C plan from servicing a larger number, that we have to keep pressure on those other entities, keeping in mind Jack's reservation about overemphasizing what the non-M+C plans represent.

My bet is, though, that if we looked in the Medicare supp world that we tend to forget, that almost all of those vendors use some of network. Presumably, they use some sort of credentialing and some sort of profiling and some sort of capturing of data to, in fact, evaluate that. Admittedly, most of it based on cost. So I do think we need to keep the pressure on, though I think leveling it up, as you said, is going to be very, very difficult and unrealistic and does impose burdens on precisely those entities that at this point in time many of our beneficiaries indicate they won't. Though I think they want more the value and security that's with that, as opposed necessarily to those entities themselves.

The final thing, and this is what we're struggling with in California again, as Janet may attest, we perhaps are somewhat unique and we have a couple of our biggest players are so heavily into capitated arrangement with delegated responsibilities. But it does drive home to me that the one common denominator is, in fact, the provider and the provider system that serves all of our beneficiaries. And to the extent that the accountability and the capturing, at least, of information that's helpful in evaluating quality at some level or quality improvement efforts, that we would be wise to think more of what is the true common denominator, as burdensome as that may be to the provider side.

DR. REISCHAUER: I have a general observation, a question, and a comment. The general observation, it's almost un-American to be skeptical about quality and quality improvement, but I'm very skeptical about this whole effort. Maybe it's because I read this material late at night and therefore find it even

though to master than Joe does, but we're having a hard time defining exactly what it is. Even if we could agree on the definitions, we have a hard time measuring it. And if we could measure it, we're not sure that the beneficiary could interpret the information correctly.

Just as an example, when you're thinking of fee-for-service versus Medicare+Choice and you might have a measure that says 80 percent of women in Medicare+Choice get an annual mammogram and only 50 percent doe in fee-for-service. I don't know if that's true or not. This might be interpreted by people as saying if I join a plan, they won't let 20 percent of the people get mammograms, as opposed to fee-for-service I know I'm in control and I'm a responsible person. So of course, I'll be part of the 50 percent. And so what is otherwise useful information turns out to skew decisions in exactly the wrong way.

My question is how sure are we that this effort at quality improvement really is leading to an aggregate improvement in overall quality? What we're dealing with here is a very complex product with thousands of component parts and dozens of dimensions to each of those parts. And necessarily we're focusing on a handful of these.

We are cognizant of the fact that the focus on these little elements takes resources, both financial and monetary resources. And it might be taking resources away from something else. So the aggregate will be a combination of improvement here and maybe degradation somewhere else. And does the benefit outweigh the cost?

Now we probably don't know anything about this, but just raising some of these issues, I think, is important.

My comment is virtually all of the examples that are given as a measure involve some condition, heart attack, followed by some follow on treatment which almost inevitably includes prescription drugs, which of course aren't covered by Medicare. There must be some examples in which the whole kit and caboodle is part of the Medicare package that we could use as examples, rather than good quality consists of after this prescribe something which isn't covered.

MR. HACKBARTH: That may be a comment on medicine. MR. MULLER: I found this discussion very helpful. Having for years tried to focus on what patients want and then trying to compare that to what professional opinion would want of the system, and seen the kind of disconnect between the two, the people who do the quality studies and write for the IOM, et cetera, have an overview of what the patient should want, which is very different from what the patient in fact asks for and requires.

One of the challenges one has, building on Bob's comment, is should we be trying to push the patient, inform the patient to be more understanding of what they should want? Or should we try to be more satisfying of the preference that, in fact, they do evince?

I've just noticed over the years and I think in some ways there's an increasing gap between what patients express as to what they want, short waiting list, choice of specialists, et cetera, versus the kind of measures that Bob has referenced as

being more what professionals would urge them to do.

Now it's obvious that using agents as a middle ground here is helpful, whether one has the kind of consumer reports or plans as agents on behalf of beneficiaries is something that people have been moving toward for years, given the overall complexity of the medical system and how hard it is for anybody to understand, once they're inside of it, they should want.

I think consistent with Bob's point, and that's really what triggered this comment, is that a lot of professional opinion, especially professional literature and the kind of call for action -- especially the IOM report -- is different than what patients express, not just here but in other countries as well, as to what they want out of the health system.

So to the extent to which we are pushing more for what the professional literature indicates they should want, that's different than what they vote for when they take action.

MR. HACKBARTH: We need to bring this to a conclusion. Karen and Mary, I hope the input will help and we'll hear more about this next meeting probably.